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Framework for An Analysis In Response to an Unusual event

INSTRUCTIONS

For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, title of responsible person for implementation and associated measure of effectiveness. If, after consideration of such a finding, a decision is made not to implement as associated strategy, indicate the rationale for not taking action.

Assure that the selected measure will provide data to assess effectiveness of the action.

Consider pilot testing of a planned improvement.

Improvement to reduce risk should be implemented in all areas where applicable, not just where the event occurred. Identify where the improvement will be implemented.

Root Cause Analysis	**Narrative Description**				**Action Plan**			
What happened? Adverse Occurrence What are the details of the event? (Brief description) Include date, day of week, time and the area/service involved.	(Write statement on attachment.)							
Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, including Root Cause(s)** Consider each aspect for analysis Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies** Implemented **YES** **DATE**			**Measures of Effectiveness**
Policy or Process (System) in which the event occurred.	The system in place related to the event is effective.				Action:			Measure:
	The system in place related to the event was carried out as intended.							
	An effective policy is in writing.							
	The policy was effectively communicated.							

	An effective procedure is in place.							

Framework for Root Cause Analysis and Action Plan In Response to an Unusual event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies** Implemented **YES** **DATE**			Measures of Effectiveness
Human Resources. (factors & issues)	Staff are properly qualified.				Action:			Measure:
	Staff are currently assessed as competent to carry out their responsibilities.							
	Staffing level plans were in place.							
	Staffing level plans were appropriate.							
	Staff level plans were implemented.							
	Staff performance in the relevant processes is evaluated.							
	Orientation & in-service training are in place							
	Human error did not contribute to the outcome.							
Environment of Care. (including equipment & other related factors)	The physical environment was appropriate for the processes/treatments being carried out.							
	A system is in place to identify environmental at risk.							
	Emergency and failure-mode responses have been planned.							
	Emergency and failure-mode responses have been tested.							
	Controllable equipment factors did not contribute to the event.							
	Controllable environmental factors did not contribute to the event.							
	Uncontrollable external factors, (natural disaster, power outages, etc.) were not a factor in this case.							

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Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES**	**NO**		**Risk Reduction Strategies**	Implemented **YES**	**DATE**	Measures of Effectiveness
Environment of Care (Continued)	An emergency preparedness plan is in place.							
Information Management & Communication Issues	Necessary information was available.							
	Necessary information was accurate.							
	Necessary information was complete.							
	Necessary information was clear and unambiguous.							
	Communication among participants was effective.							
	No barriers to communication were identified.							
Standard of Care	The quality of care and services met generally accepted community standards.							
Leadership: Corporate culture	Leadership is involved in the evaluation of adverse patient care occurrences,.							
Other	Note other factors that influenced or contributed to this outcome? Note other areas of service impacted.							

Results of literature review (include key citation(s)):

Executive Summary of the Analysis (note critical findings):

List titles of Root Cause Analysis participants i.e., Director of Nursing